



APPLICATION FOR ENDORSEMENT AS A HEALTH SERVICE PROVIDER IN PSYCHOLOGY

State Form 20231 (R10 / 12-02)

Approved by State Board of Accounts, 2002

Agency

Indiana State Psychology Board
HEALTH PROFESSIONS BUREAU
402 W. Washington St., Rm W066
Indianapolis, IN 46204
Telephone: (317) 234-2057

FOR AGENCY USE ONLY:

Date reviewed:	Decision:	Initials
----------------	-----------	----------

Fee \$	Date fee paid (month, day, year)
Receipt number	Endorsement issuance date (month, day, year)

* Your Social Security number is required pursuant to IC 4-1-8-1.

DO NOT WRITE ABOVE THIS BOX

Name (last, first, middle, maiden)		Social Security number *	
Home address (street, number / rural route)		City	State
			ZIP code
Telephone number (daytime)	Date of birth (month, day, year)	Place of birth	E-mail address

DOCTORAL EDUCATION

Name of school	Department	Title of program	
Street address		Dates attended	Degree earned
APA approved at time of graduation? <input type="checkbox"/> Yes <input type="checkbox"/> No			

TRAINING IN AN ORGANIZED HEALTH SERVICE TRAINING PROGRAM (PRE-DOCTORIAL INTERNSHIP)

A. Name and address of internship program			
B. APA approved at the time of completion? <input type="checkbox"/> Yes <input type="checkbox"/> No		C. APPIC approved at the time of completion? <input type="checkbox"/> Yes <input type="checkbox"/> No	
D. Inclusive dates of internship (months, days, years) FROM: TO:		Total hours worked	
E. Name of supervising psychologists and their certification - licensure status			
	Name	Degree	State Where Certified - Licensed
Director of Training			
Other supervising Psychologists			
F. Number of interns in program at the time you were in the program	G. Approximate number of hours of direct supervision per week (individual, not group supervision)		H. Number of seminar hours per week

EXPERIENCE IN A SUPERVISED HEALTH SERVICE SETTING (Post-Doctoral Work Experience) (Attach additional sheets for multiple settings)		
Name of facility		
Address (number and street, city, state, ZIP code)		
Your title	Name of supervisor	Supervisor's degree
Inclusive dates (months, days, years) FROM: _____ TO: _____		Number of hours of supervised experience
Number of hours per week of direct face-to-face supervision (individual, not group) you received.		Number of hours you engaged in direct patient contact
Number of hours you supervised others.	If you supervised others, were they: <input type="checkbox"/> Psychology graduate students <input type="checkbox"/> Other (describe) _____	
Number of hours you engaged in teaching.	Number of hours you engaged in research.	

If your answer is "Yes" to any of the following, explain in a notarized affidavit, including all related details. Describe the event including location, date, and disposition. If malpractice, provide name of plaintiff. Falsification of any of the following is grounds for permanent revocation of an endorsement issued pursuant to this application.		
1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Have you ever been denied a license, certificate, registration, permit, or endorsement to practice psychology, or any regulated health occupation in any state or country (including Indiana)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Are you now, or have you ever been treated for a drug or alcohol problem?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Have you been charged with a crime related to drug or alcohol abuse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Have you ever been convicted of, pled guilty or <i>nolo contendere</i> to:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
A. A violation of any Federal, State or local law relating to the use, manufacturing, distribution or dispensing of controlled substances or drug addiction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
B. Any offense, misdemeanor or felony in any state? (Except for minor violations of traffic laws resulting in fines.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Have you ever had a malpractice judgement against you or settled any malpractice action?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

APPLICATION AFFIRMATION	
I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.	
Signature of applicant	Date signed (month, day, year)

AUTHORIZATION FOR RELEASE OF INFORMATION	
<p>I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Health Professions Bureau of Indiana any files, documents, records or other information, pertaining to the undersigned, requested by the Bureau or any of its authorized representatives in connection with processing my application for endorsement.</p> <p>I hereby release the aforementioned persons, firms, officers, corporations, associations, organization, persons and institutions from any liability with regard to such inspection or furnishing of such information.</p> <p>I further authorize the Health Professions Bureau of Indiana, or the Indiana State Psychology Board to disclose to the aforementioned organization, persons and institutions any information which is material to my application, and I hereby specifically release the Bureau from any and all liability in connection with such disclosures.</p> <p>A photostatic copy of this authorization has the same force and effect as the original.</p>	
AFFIRMATION	
I hereby swear or affirm that I have read the above statements and agree to the same.	
Signature of applicant	Date signed (month, day, year)

YOU MUST COMPLETE FORM A AND B (attached)



ENDORSEMENT AS A HEALTH SERVICE PROVIDER IN PSYCHOLOGY / VERIFICATION OF EXPERIENCE IN AN ORGANIZED HEALTH SERVICE TRAINING PROGRAM (Internship)

State Form 20231 (R10 / 1-02)

Approved by State Board of Accounts, 2002

Indiana State Psychology Board

FORM A

INSTRUCTIONS - ALL APPLICANTS:

Complete the top section

Make copies and send this form to the Director of Training of your experience in an organized health service training program (internship).

Direct the individual(s) to send this form directly the Health Professions Bureau.

If the Director of Training is not available, another psychologist associated with the internship may complete the form.

If a psychologist is not available, you must provide a written explanation to the Board.

1. Name (last, first, middle, maiden)			
2. Home address (street, number / rural route)	City	State	ZIP code
3. License number	Date of issuance (month, day, year)	Date of birth (month, day, year)	
I authorize _____ to furnish the Indiana State Psychology Board / Health Professions Bureau with the following information.			
Signature of applicant		Date of signed (month, day, year)	

TO:	
Please verify that _____ has received acceptable, supervised experience in an organized health service program (internship) by providing the following information.	
1. Name and address of the agency providing the training program	
2. Your name and current address	
3. Your title at the agency at the time the applicant was in the program	
4. What role did you play in the internship?	
5. Did you directly supervise the applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No	If No, what was your relationship to the applicant?
6. Type of patient / client population	
7. When did the applicant receive training in your program / internship? (please provide exact beginning and ending dates)	
FROM:	TO:
a. Was the internship APA approved at the time of completion? <input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Was the internship APPIC approved at the time of completion? <input type="checkbox"/> Yes <input type="checkbox"/> No	
c. Number of hours per week applicant worked in this setting	
d. Number of hours per week applicant received individual, not group, supervision	
e. Duration of the supervision (number of weeks or months)	
f. Total number of hours the applicant worked in this setting	
8. Number of interns in the program when the applicant was in the program.	

See Reverse Side

9. NAME AND DEGREES OF SUPERVISING PSYCHOLOGISTS

Name	Degree (<i>at the time the applicant was in the program</i>)	State Where Certified / Licensed

10. Please give a brief description of the applicant's internship experience

11. Was the internship satisfactorily completed?

☐ Yes ☐ No

If No, please attach an explanation.

12. At the time of supervision

A. Were you licensed or certified in Indiana?

☐ Yes ☐ No

B. If you were licensed or certified in Indiana, were you endorsed as a health service provider in psychology?

☐ Yes ☐ No

If you were not licensed or certified in Indiana and HSPP, or were not listed in the National Register, attach your resume.

VERIFICATION FORM AFFIRMATION

I hereby swear or affirm, under the penalty of perjury, that the statements made in this verification are true, complete and correct.

Signature

Date signed (*month, day, year*)

Please respond as soon as possible so that the applicant's endorsement request may be completed without delay.

Please send all responses to: **HEALTH PROFESSIONS BUREAU**
402 W. Washington St., Rm W066
Indianapolis, IN 46204

Attn: Psychology Group

Thank you for your assistance in this matter.



ENDORSEMENT AS A HEALTH SERVICE PROVIDER IN PSYCHOLOGY / VERIFICATION OF EXPERIENCE IN AN ORGANIZED HEALTH SERVICE TRAINING PROGRAM (Post Degree)

State Form 20231 (R10 / 1-02)

Approved by State Board of Accounts, 2002

Indiana State Psychology Board

FORM B

INSTRUCTIONS - ALL APPLICANTS:

Complete the top section.

Make copies and send this form to each individual who supervised your experience in a health service setting (post-degree / work experience). Direct the individual(s) to send this form directly the Health Professions Bureau.

1. Name (last, first, middle, maiden)			
2. Home address (street, number / rural route)	City	State	ZIP code
3. License number	Date of issuance (month, day, year)	Date of birth (month, day, year)	
I authorize _____ to furnish the Indiana State Psychology Board / Health Professions Bureau with the following information.			
Signature of applicant		Date of signed (month, day, year)	

TO:	
Please verify that _____ has received acceptable, supervised experience in an organized health service setting (<i>post-degree work experience</i>) by providing the following information.	
1. Name and address of the facility in which the experience was obtained	
2. Your name and current address	
3. Your title in the health service setting during the time you supervised the applicant	
4. Type of patient / client population	
5. INCLUSIVE DATES AND NUMBER OF HOURS PER WEEK THE APPLICANT WORKED IN THIS SETTING	
Dates	Hours
a. Number of hours per week you directly supervised applicant (<i>individual, not group, supervision</i>)	
b. When did you supervise the applicant? (<i>provide exact beginning and ending dates</i>)	
c. Number of hours of experience completed by the applicant while under your supervision	
d. Number of hours of direct patient contact by the applicant while under your supervision	

6. Briefly describe the nature of the applicant's work <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
7. Was the supervised experience satisfactorily completed by the applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, please attach an explanation.
8. At the time of supervision: <div style="display: flex; justify-content: space-between;"> A. Were you licensed or certified in Indiana? <input type="checkbox"/> Yes <input type="checkbox"/> No </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> B. If you were licensed or certified in Indiana, were you endorsed as a health service provider in psychology? <input type="checkbox"/> Yes <input type="checkbox"/> No </div> <p style="margin-top: 10px;">If you were not licensed or certified in Indiana and HSPP, or were not listed in the National Register, attach your resume.</p>

VERIFICATION FORM AFFIRMATION		
I hereby swear or affirm, under the penalty of perjury, that the statements made in this verification are true, complete and correct.		
Signature of supervisor	Printed name of supervisor	Date signed (<i>month, day, year</i>)

<p>Please respond as soon as possible so that the applicant's endorsement request may be completed without delay.</p> <p>Please send all responses to: HEALTH PROFESSIONS BUREAU 402 W. Washington St., Rm W066 Indianapolis, IN 46204</p> <p style="text-align: center; margin-top: 20px;">Attn: Psychology Group</p> <p style="text-align: center; margin-top: 20px;">Thank you for your assistance in this matter.</p>
--